Utah's
Strategic Prevention Framework State Incentive Grant
State Strategic Plan

November 2007

UT - 13929

State of Utah
Strategic Prevention Framework State Incentive Grant
(SPF SIG)
Statewide Plan
2007

ASSESSMENT

1. ASSESSING SUBSTANCE USE AND RELATED CONSEQUENCIES (EPI PROFILE)

In preparation for the SPF-SIG, Utah engaged in a year-long data examination and evaluation process through the State Epidemiological Outcomes Workgroup (SEOW). The SEOW included members from the Utah Department of Health, Utah Division of Substance Abuse & Mental Health, local substance abuse prevention agencies, and Bach-Harrison, LLC a contractor that conducts and analyzes survey research. The SEOW worked for more than one year to compile and evaluate Utah-specific substance-related use and consequence data and compare it to national measures as well as other states' data. As a result of this effort, the SEOW generated the State Epidemiological Profile that includes 28 indicators of substance use consequences and 24 indicator estimates of substance consumption for youth and adult populations in Utah. The attached data tables summarize the indicators reported upon by the SEOW (See Appendix A and B).

The data in State Epidemiological Profile are organized by three general substance categories: a) alcohol, b) tobacco, and c) other drugs. Substance use consequence and consumption data are presented separately. The summary data tables act as both an index and a summary of all 28 consequence and 24 consumption indicators included in the report. These tables allow readers to compare outcome and consumption indicators within substance category readily across a variety of attributes. Among the attributes provided in the consequence reference tables are the following:

1) *Indicator Name* – The name or description of the indicator
2) *Years* – The specific (data) years which are summarized in the table
3) *Average Annual Number of Cases* – The average number of cases of the substance consequence that occurred during the specified years
4) *Average Rate per 100,000 Population* – The average annual rate of cases per 100,000 population during the specified years
5) *UT:USA Rate Ratio* – Provides a comparison of the rate in Utah to the national rate during the same years; Ratios less than one reflect a lower state rate vs. the national rate, while ratios above one reflect a higher state rate vs. the national rate
6) *Trend* – The general trend in the number of cases or rate of incidence over the most recent years of data available
7) *Time from Use to Outcome* – A general index of the amount of time between use of the substance to the onset of the consequence (immediacy)
8) *Strength of Relationship* - A general index of the extent to which substance use is a strong determinant of or is highly correlated with the consequence
9) *Data Source* – Specifies the source from which the indicator was obtained; additional information about each source is contained in the appendices of the report
10) *Page* – Provides the page number where more detailed information and charts for each indicator can be found

Some data gaps were identified during the SEOW process. There is a paucity of data at the county or district level compared to the state level. This is especially true of adult consumption data. There is also a lack of data for specific groups that may be at higher risk of outcomes such as racial or ethnic groups, or specific age groups such as senior citizens.

Utah is fortunate to experience relatively low rates of substance use and substance use related outcomes compared to the nation. Identified rates of substance use and outcomes among Utah adults are less than the United States as a whole for all reported measures except suicide and reported property crimes. Both of these outcomes have been related to substance use but are not proximal (immediate consequence) indicators of substance use. Youth substance abuse rates are also generally much lower than the national average. In fact, 30 day use rates of Utah youth for the most commonly reported substances (alcohol, tobacco and marijuana) are about half of the national rates for these substances.

Prioritization Process

The information collected in the State Epidemiological Profile was used to establish state level substance use and abuse prevention priorities for the SPF-SIG. During the prioritization process, consideration was given to all of the attributes specified in the reference tables, including: number of cases, rates, time from use to outcome, strength of use/outcome relationship, etc. Each of these attributes provides unique and important information that was integral in determining the most pressing substance use and consequence issues facing the state. Additionally, the data were examined geographically and by demographic variables to determine which parts of the state and which populations are of the highest need. In particular, the data were broken out at the Local Substance Abuse Authority District level and by age, where appropriate, to determine need by region and populations.

It is important to keep in mind the relatively low rates of substance use and substance related consequences that Utah experiences. Therefore, it has been and should continue to be the goal of prevention professionals to achieve the lowest rates possible for Utah rather that achieving rates lower than the nation or similar states.

After discussion and review of the indicators presented in the State Epidemiological Profile, two state-level priorities were selected: prescription drug abuse and alcohol-related motor vehicle crashes. Consideration was given to various dimensions of each indicator including the magnitude, time, and severity.

Fatal overdoses related to prescription drugs have emerged in recent years as the leading cause of poisoning death in Utah. This is a problem of middle-aged adults with the average person aged 40 years at death. Rates of these overdoses have increased faster in rural parts of the state than in the urban centers, and as of 2003, the death rate due to poisoning surpassed that from motor vehicle crashes.

Alcohol-related motor vehicle crashes continues to be a problem in Utah and the United States. While our rate is much lower than the national rate, this was still identified as a prevention priority due to the severity of outcome and short time from exposure to outcome. It is reasonable to expect that change is possible in the alcohol-related motor vehicle crash rate during the time frame of the SPF-SIG process, and even a small rate reduction will create savings in terms of both economic costs and human lives. As a related consumption indicator, underage alcohol consumption will be addressed in high priority areas in Utah.

2. CAPACITY AND INFRASTRUCTURE

At the state level, prevention services are managed through the Division of Substance Abuse & Mental Health (DSAMH). Mark Payne is the Director of DSAMH, supported by Brent

Kelsey, Assistant Director, and the staff specifically assigned to prevention. Within the Division, there is collaboration and support between mental health, substance abuse treatment and prevention teams.

There are a number of different governing groups that oversee substance abuse prevention services. The entire Division is monitored and overseen by the State Board of Substance Abuse, our policy making group. We also have a guiding council, the Utah Prevention Advisory Council (UPAC). This group allows for collaboration between other agencies throughout the state and also focuses on prevention. The State Epidemiological Outcomes Workgroup (SEOW) was convened after the State Division of Substance Abuse and Mental Health received an SEOW grant. The SEOW is charged with the task of collecting data and analyzing it so it may be useful for other agencies as well as our prevention services. After Utah received the SPF Grant, the Project Management Team (PMT) was created. The PMT was created to take the Epidemiological Profile data and make statewide priorities, as well as provide technical assistance to the SPF communities throughout the state.

Our State is fortunate to have a great prevention network in place. Utah is made up of 13 Local Substance Abuse Authority areas (LSAA). The directors of these agencies meet monthly along with their county commissioners through the Utah Association of Counties. Within each of these agencies, there is a Prevention coordinator. The 13 Coordinators convene quarterly at the Prevention Coordinators Network meetings. The Coordinators provide direct service prevention in their respective areas.

The Prevention Coordinators from all LSAAs have received training from WESTCAPT regarding the SPF process. The State will provide technical assistance throughout the duration of the grant to help the LSAAs at each stage of the SPF process. In addition, Most of the coordinators are currently being trained in Communities That Care (CTC) as a planning model for creating and maintaining local coalitions, and some of the LSAAs have several functioning coalitions.

Despite these resources, the LSAAs do have challenges. Cultural issues along with the rural and frontier nature of many areas of Utah bring unique challenges. Some LSAAs have difficulty maintaining consistent staff. The impact on the community is a lack of consistent presence to provide prevention services. Additionally, while some LSAAs have multiple functioning coalitions, others struggle to maintain one active coalition.

The service providers within the LSAAs collect demographic information and record the number of evidenced based programs on a system called Prevention Administration Tracking System (PATS). This system collects demographics (race, ethnicity, gender, age), number of participants, type of programming (universal, selective, indicated), and number of sessions. It does not currently collect specific National Outcomes Measures down to the program level or generate reports that are accessible or available to the LSAAs. It is one of our goals to rectify this problem prior to the end of the SPF SIG Grant. The Division will continue to provide technical assistance to the LSAAs in order to collect the necessary data for the NOMs and for evaluation purposes. We have contracted with Bach Harrison, LLC, as our project evaluator. Bach Harrison has and will continue to provide technical assistance related to evaluation, data collecting, and fidelity to the LSAAs. Bach Harrison has also continued to support staff at the State level.

3. CRITERIA AND RATIONALE FOR SPF SIG PRIORITIES

In April 2007, after the EPI Profile was submitted and approved, the Project Management Team (PMT) was formed. The PMT is comprised of Susannah Burt, Craig PoVey, Tricia Winder, Benjamin Reaves, Dr. Edward Ho, Dr. Stacy Eddings, Dr. Jamie Smith and Verne Larsen. The objective of the PMT was to look at the data collected by the SEOW, identify possible priorities and make the final decision regarding Utah's statewide priorities. Based on the EPI Profile data, the PMT identified two priorities – Alcohol Related Motor Vehicle Crashes (ARMVC) and Prescription Drug Abuse.

The PMT set up selection guidelines that were used to identify these two priorities. First, the magnitude of the indicator needed to be large enough that we could reasonably expect to have an impact on reducing it. As mentioned earlier, some of Utah's indicators are so low in magnitude that having a noticeable impact on their numbers would be difficult; we wanted to focus on those indicators with the highest magnitude. Second, we noted the rate. Similar to magnitude, Utah's low rates can make demonstrating change difficult and we wanted to focus on the highest rates. Third, we looked at trend to determine whether the indicator is increasing or decreasing in occurrence. While a decreasing trend did automatically eliminate something as a priority, we wanted to give more weight to those with increasing trends. Finally, for each consequence we reviewed the resources that were already allocated to the consequence, how quickly we would be able to evaluate change with respect to that consequence, and political and social will/readiness for addressing the consequence. During the prioritization process, consideration was given to all of the attributes specified in the reference tables from the Epidemiological Profile. Each of these attributes provides unique and important information that was integral in determining the most pressing substance use and consequence issues facing the state. The PMT decided to *not* use a formal matrix or scoring sheet due to the fact that there would still be some subjectivity applied to the scoring.

After setting up our guidelines, we quickly filtered out all of the tobacco consequences. This was due to the fact that: (1) it is unlikely we would be able to show a significant change in the consequences within the timeframe of the grant; and (2) the Utah Department of Health already focuses heavily on tobacco thus directing a great deal of resources (both money and people) toward tobacco use. We also eliminated cirrhosis of the liver as a result of the grant timeline. We did not feel that we could demonstrate a change in this consequence within five years. Ultimately the consequences were selected based upon their numbers, rates, trend, ability to change and community/political readiness.

Additionally, the data was examined geographically and by demographic variables, such as race, ethnicity and age where possible, to determine which parts of the state and which populations have the highest need. In particular, the data was broken out at the Local Substance Abuse Authority District level and by age, where appropriate, to determine need by region and populations.

After considering all of the above factors, two consequences stood out as strong candidate for priorities: Alcohol Related Motor Vehicle Crash (ARMVC) fatalities and Accidental and Undetermined Intent Non-Illicit Drug Poisoning Deaths (NIDPD). The average annual incidence of ARMVC fatalities is 74. Through the prioritization process we noted that even though our ARMVC rate remained stable, we acknowledged that the ARMVC issue would be easier to track and evaluate due to the available resources. Recently, attention on underage

drinking has increased in Utah. Utah Highway Safety is also mounting a new media campaign related to DUIs and drunk driving. Since the state is already attempting to mobilize around the issue of alcohol related motor vehicle crashes, it made sense to try and impact this consequence.

Non-Illicit Drug Poisoning Deaths pose more of a conundrum. While the incidence and rate are high and the trend is increasing with a strong relationship between time of use and outcome, there is very little data at the community level to evaluate. The average annual incidence of Non Illicit Drug Poisoning Deaths is 76. We will focus on the prescription narcotics, which are pain killers. There have also been several high profile arrests and articles surrounding prescription drug abuse and deaths. The communities are searching for ways to influence change regarding prescription drug overdose and death.

It is important to keep in mind the relatively low rates of substance use and substance related consequences that Utah experiences. Therefore, it has been and should continue to be the goal of prevention professionals to achieve the lowest rates possible for Utah rather than feeling "finished" once rates are lower than the nation or our neighbors.

4. SPF SIG PRIORITIES

Below is a table to describe the Statewide Priorities.

Consequence/Indicator	**Consumption Pattern(s)**
Alcohol related motor vehicle crashes (includes: property, injury, & fatalities) lifespan	• 30 day use (SHARP and NSDUH) • Binge drinking (SHARP and NSDUH) • Ride with a drunk driver • Driving drunk
Non Illicit Drug Related morbidity and mortality (focus on Prescription Drugs)	• Treatment Needs data • 30 day drug use (SHARP, UHEBHS)

*SHARP – Student Health and Risk Prevention Survey
*NSDUH – National Survey of Drug Use and Health
*UHEBHS – Utah Higher Education Behavioral Health Survey

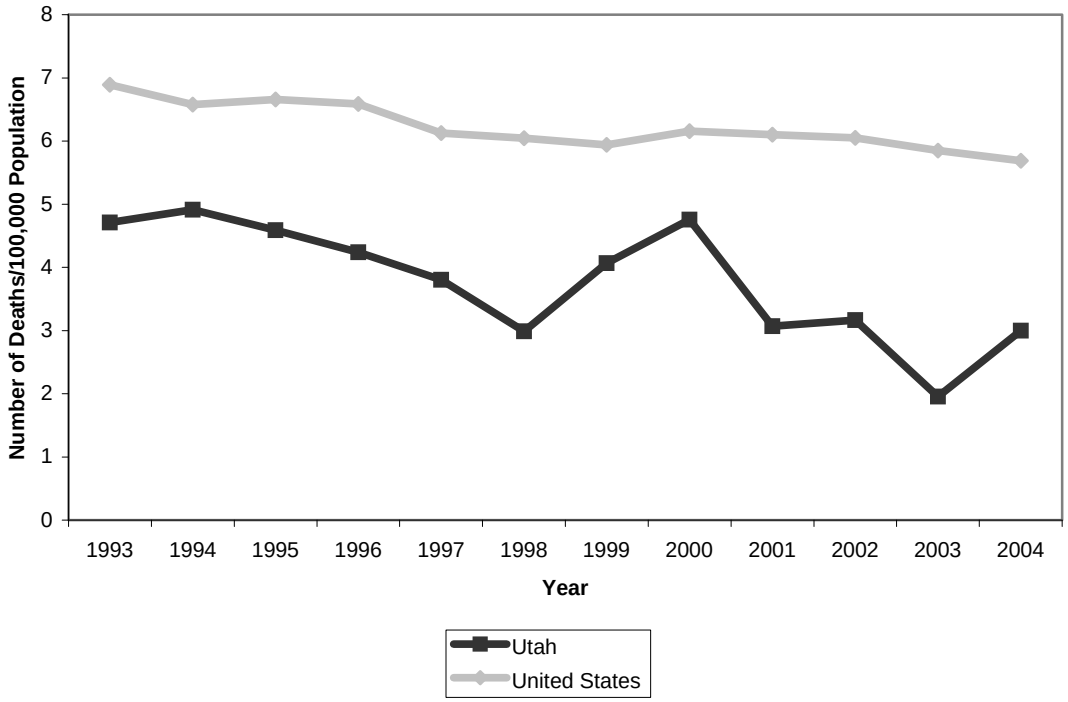
Table1 Alcohol Mortality Indicators – Alcohol Related Motor Vehicle Fatalities

Indicator	Years	Average Annual Number of Cases	Average Rate per 100,000 Population	UT:USA Rate Ratio	Trend	Time from Use to Outcome	Strength of Relationship
Alcohol Related Motor Vehicle Crash Fatalities	2000-2004	73.5	32	0.53	Stable	Immediate	Strong
# of Fatal Alcohol Related Vehicle Crashes	2000-2004	64.8	28	0.53	Stable	Immediate	Strong
Proportion of Fatal Motor Vehicle Crashes Related to Alcohol	1990-2003	26%	41%	0.63	Slightly Decreasing	Immediate	Medium

*Indicator source 13.

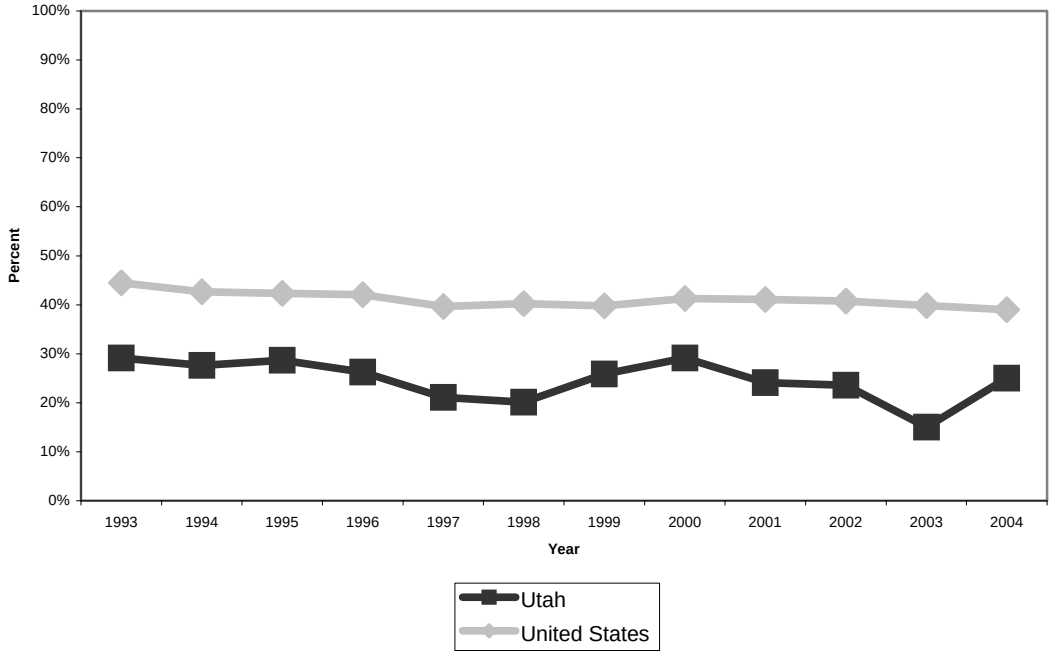
Motor vehicle fatalities make up a large portion of accidental injuries in both Utah and the nation. Utah experienced an average of 73.5 fatalities a year between 2000 and 2004 as a result of alcohol related crashes. The rate of fatalities due to alcohol related motor vehicle crashes in Utah has been 50-60% of the national rate with this rate being stable over the past four years. However, as you can see in figure 1, the number of deaths due to alcohol related motor vehicle crashes increased sharply from 2003 to 2004 (the last year data was available). Additionally, the percentage of fatal crashes that are alcohol related also increased from 2003 to 2004 (See figure 2).

Figure 1: Alcohol Related Motor Vehicle Fatalities



As seen in figure 2 below, the percentage of fatal crashes related to alcohol use has consistently been lower in Utah compared to the national average. Where as about 40% of fatal accidents are alcohol related for the nation, only about 25% of fatal accidents are alcohol related in Utah.

Figure 2: Percent of Fatal Crashes that are Alcohol Related



The figure 3 includes separate lines for all drivers and drivers <21 years old. While the Utah <21 year old proportion of drivers involved in fatal accidents is lower than the national, the proportions are much less stable than the national proportions and increased qualitatively from 2000-2002.

Figure 3: Percent of Drivers Involved in Fatal Accidents (among all drivers involved in fatal accidents) over the Legal BAC: Utah vs. US

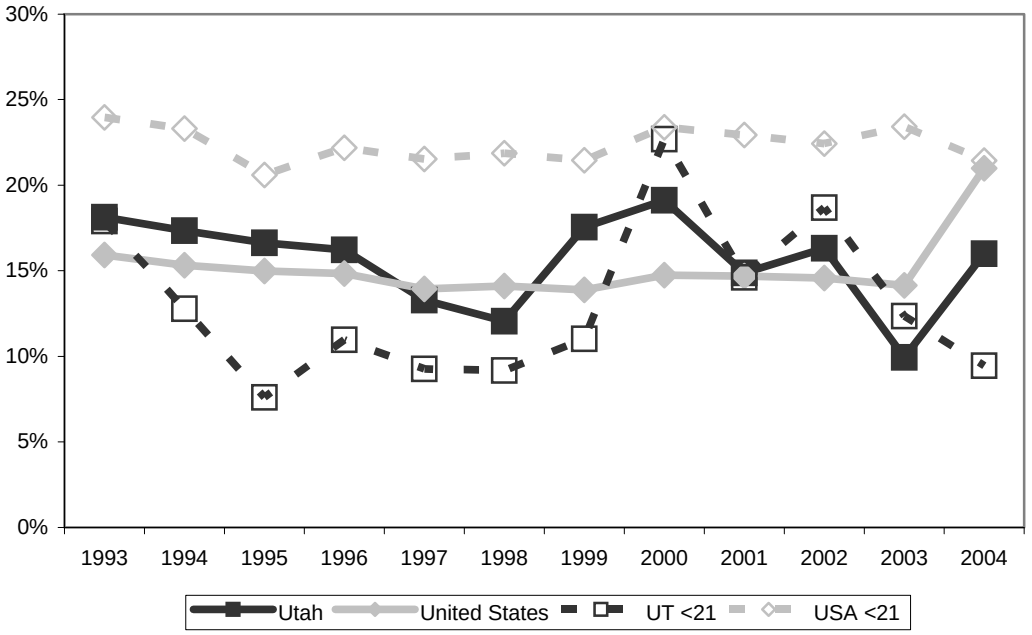


Figure 4: Alcohol Related Fatal Motor Vehicle Crash Rate

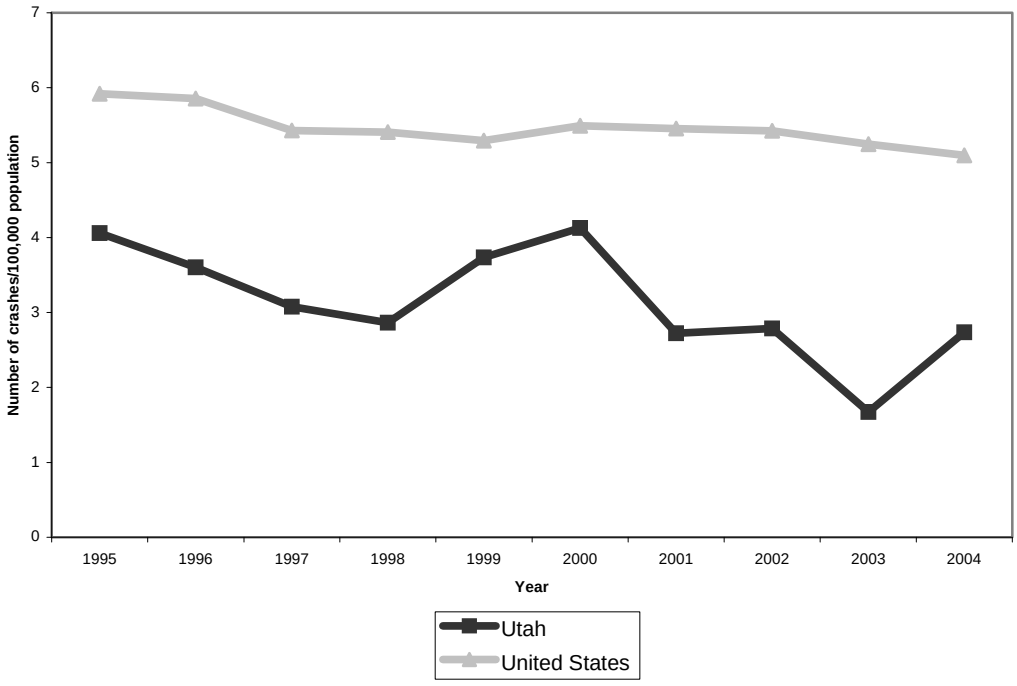


Table 2 Other Drug Mortality – Drug Poisoning

Indicator	Years	Average Annual Number of Cases	Average Rate per 100,000 Population	UT:USA Rate Ratio	Trend	Time from Use to Outcome	Strength of Relationship
Accidental and Undetermined Intent Drug Poisoning Deaths *	1999-2004	222	9.4	Not Available	Increasing	Immediate	Strong
Drug Use[1]	1990-1998	4	0.22	0.44	Increasing	Immediate	Strong
Number of Drug Poisoning Deaths Investigated by the Medical Examiner[2]	1991-2005	215	Not Applicable	Not Available	Increasing	Immediate	Strong
Number of Accidental and Undetermined Intent **Illicit** Drug Poisoning Deaths[2]	1991-2005	75	3.4	Not Available	Increasing, then Stable	Immediate	Strong
Number of Accidental and Undetermined Intent **Non-Illicit** Drug Poisoning Deaths[2]	1991-2005	76	3.3	Not Available	Increasing	Immediate	Strong

*Indicator source 7.
[1]Indicator source 19-23.
[2]Indicator source 9.

* ICD-10 Codes: X40–44; Y10–14 in the Underlying Cause of Death field

Based on the data, it is apparent that non-illicit drug use is on the rise in the State of Utah. Two main sources of data are used in estimating mortality associated with drug use. These sources are death certificate data and the state medical examiner data. Limitations inherent in data sources affect the numbers of deaths counted in different categories of drug poisonings when extracted from different data sources. Deaths counted using death certificates indicate the manner or intention (suicide or accident) of death within the code for the underlying cause of death, but this code is not specific for the type of drug (illicit or non-illicit). Medical examiner data is not coded, so it is more difficult to use, but more data are available regarding the causative drug. In addition, the medical examiner may not investigate every drug poisoning death, so the numbers available likely represent a very conservative estimate. Some of the variation in the above table is caused by differences in data collection and reporting.

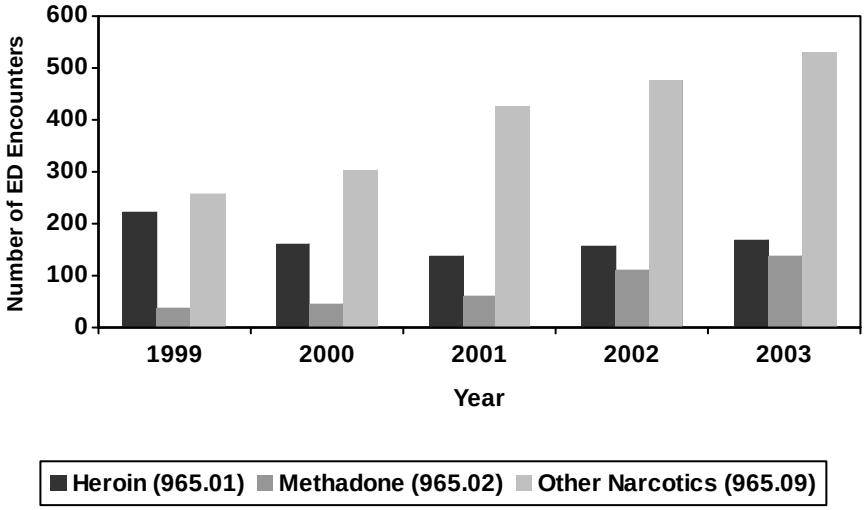
Unfortunately, there have been significant increases in the numbers of drug poisoning deaths in recent years. As such, the mean value reported above may not do justice in illustrating the drug mortality issue facing the state. The last two rows in the table are subsets of the third row.

Separating out these categories helps to illustrate the drug overdose situation in Utah. Chart 1 below provides a clearer picture of the situation regarding fatal drug poisoning in Utah.

In Utah, prescribable narcotics such as methadone and oxycodone now contribute to more deaths each year than illicit drugs such as heroin.

Not all drug overdose incidents are fatal. The number of overdose incidents presenting at Utah emergency departments is also increasing but the majority of the patients survive and therefore are not captured in the medical examiner or death certificate data. The emergency department encounter data helps to provide a more complete picture of non-illicit drug use. It needs to be noted that "other narcotics" in chart 1 primarily represents pain killers.

Chart 1: Utah Emergency Department Encounters for Narcotics Overdose, 1999-2002



CAPACITY BUILDING

1. AREAS THAT NEED STRENGTHENING

Originally, the area that needed strengthening at the state level was capacity. However, this is no longer a deficit as the State hired a coordinator and identified a budget officer. The Project Director, the Project Coordinator and the State Epidemiologist all attended the new grantees meeting to receive necessary training to begin the 5 Step SPF process. In addition, the State put out a Request for Proposal (RFP) for the Project Evaluator. Although the process to procure a Project Evaluator was lengthy, after seven months Bach Harrison, L.L.C. was contracted as the Project Evaluator. With that done, all the personnel have been hired and the State is ready to continue in the 5 Step process.

The State of Utah has a data collection system already in place, the Prevention Administration Tracking System (PATS). However, PATS needs to be enhanced in terms of data reporting and the accessibility of the data to the local areas and agencies. The State is committed to enhancing PATS to collect the National Outcomes Measures down to the program level. If PATS is unable to collect the necessary data, the State will look at alternate systems.

2. STATE- AND COMMUNITY- LEVEL ACTIVITIES

Additional capacity building activities at the state level will include the following: grantee meetings, participation in the audio calls provided by PIRE, training with WEST CAPT on the SPF process, and frequent contact with the CSAP Project Officer. The Coordinator and Project Director will continually review and train the members of UPAC, State Board, and the Prevention Coordinators Network on the 5 Step SPF Process. WEST CAPT will also be assisting in training the Prevention Coordinators Network. SPF SIG Staff members will attend any National Meetings throughout the year.

It will be the responsibility of the Prevention Coordinators to train and staff their respective area. This will include potentially training their advisory board/community coalitions on the SPF Process and hiring personnel to meet the needs of the grant and the community. The Prevention Coordinator for each LSAA will continue to attend quarterly meetings (these are the Prevention Network meetings) and receive additional training/review as needed. The State will provide as much technical assistance as needed to achieve these goals.

The State goal is that each LSAA will maintain a minimum level of capacity that will be built during the SPF Grant. This may include everything from maintaining staffing levels to continuing data collection. It is the goal of the State to use the SPF SIG as a catalyst for the LSAAs to request additional resources from their communities.

3. THE ROLE OF THE SEOW

The current Epidemiological Profile compiled by the SEOW focuses on presenting state and national data, and illuminating substance use and consequence issues and trends at the state level. Now that this is completed, the SEOW has entered into a new phase of its existence. In addition to annually updating the EPI Profile, the SEOW will continue to attempt to paint a more complete picture for the LSAAs by filling in the data gaps that were identified by the EPI Report. The SEOW will also assist the LSAAs by identifying intervening variables that may impact them.

Gaps identified include a paucity of data at the county or district level compared to the state level. This is especially true of adult consumption data. There is also a lack of data for specific groups that may be at higher risk of outcomes such as racial or ethnic groups, or specific age groups such as senior citizens. Therefore, future work by the SEOW will begin to analyze substance use and consequence issues and trends at sub-state levels and in more specific populations within the state. One way gaps may be addressed includes collaboration with other State agencies that conduct surveys to reach untapped communities or populations. The SEOW remains open to suggestions for additional data relevant to substance use or consequence that is available.

PLANNING

1. PLANNING MODEL

The planning model for the State of Utah will follow a hybrid equity model, with allocation across the state based on both contribution and need. The model, described in greater detail below, will allocate funds to each of the thirteen Local Substance Abuse Authorities (LSAA) based on each LSAAs relative contribution to the magnitude of the priority's occurrence within the State and the demonstrated need of the LSAA. Note that most LSAAs will only focus on one priority; which priority(s) an LSAA will focus on is driven by the data (as described below).

There are a number of reasons that a statewide allocation makes sense for Utah. Due to Utah's smaller size and population, there are adequate funds to impact the prioritized issues statewide without sacrificing the prevention efforts in any district. Not funding all LSAAs would likely lead to unused money by the districts that were funded. Further, there is a data demonstrated need in all districts for at least one of the priorities with the exception of one or two LSAAs. However, there would be political fallout for funding all except those two. Much effort has been put into building relationships between the state and local districts that would be lost if not all received funding. In addition, as a vital component of sustaining the SPF in Utah well beyond the grant, the State feels it is important build capacity across the entire state. While these two areas may have less need now, their need may increase in the future. Infusing the Strategic Prevention Framework process throughout the entire state will help lay the foundation for the process to be used in all aspects of prevention planning and ensure that Utah's rates stay low despite its rising population. It is our intent to sustain the SPF process throughout the entire state well beyond the SPF-SIG Grant, beginning with integrating the SPF process into the SAPT Block Grant requirements.

2. ALLOCATION APPROACH

The indicators that contribute to each of the State priorities are listed in Tables 4 and 5. The State and the PMT have reviewed the data for each indicator and designated what priority each Local Substance Abuse Authority will focus on based on how the LSAA contributes in magnitude and need on each indicator for each priority.

Table 4.

Construct	**Alcohol related motor vehicle crashes**
Consequence Indicators	ARMV fatalities
	ARMV injuries
	ARMV PD
Consumption Indicators	Drinking/driving
	Binge drinking
	Heavy problem drinking
	30 day use

Table 5.

Construct	**Non-illicit drug related morbidity & mortality**
Consequence Indicators	ER visits
	Fatalities
Consumption Indicators	Shipment amounts
	30 day use rates
	Lifetime use rates
	Past year use rates
	Poison Control calls

For year two of the SPF SIG, the 13 LSAAs will be allocated funding based on the following.

The state decided to prioritize the top five LSAAs for each priority in order to focus additional resources on those areas with the goal of showing change at the state level. By funding all thirteen LSAAs, but putting the emphasis on the top five districts, we hope to maximize the

possibility of state level change. Also, note that we capture approximately 80% of the State's total cases within the top five LSAAs for each priority. The top five LSAAs for each priority were determined through Z-score rankings based on weighting number 75% and rate 25% on the selected indicators (shown in Tables 4 and 5). Z-scores were used because they convert the indicators to the same scale (a mean of zero and a standard deviation of one) to allow for combining the indicators (and then ranking the LSAAs) in a meaningful comparison. Each indicator was given equal weight. Number was weighted more heavily than rate due to the goal of showing change on the state level and to the fact that Utah has low numbers over all. A district could be in the top five for both priorities. This resulted in six districts being prioritized between the two priorities (four districts were prioritized for both priorities; two were prioritized for one priority). The allocation for the six prioritized LSAAs starts with $25,000 as a base and then adds additional money depending on population, need and the number of priorities (one or two) the LSAA will address. Specifically, the two main components of the formula are the rate and number of cases for the indicators related to the priority problem. There is equal funding for both priorities and, again, equal weight was given to each indicator within each priority. Equal weight was also given to rate and number for each indicator (unlike the initial rankings) to give magnitude and need equal footing.

The remaining seven, non-prioritized districts will receive $100,000 the first year and $75,000 each subsequent year. The state will specify which priority each LSAA is to focus on based on the available state data. Two LSAAs do not have a clear focus point based on the available state data and the community will submit their own data and justification for which priority they believe they should focus on.

Table 6 provides the funding amount for each LSAA, as well as the priority they will be focusing on and their respective contribution to magnitude and rate of their identified priority problem. Note that indicator data is only provided for the priority that the LSAA is being funded to address with SPF SIG funds. That is, the table presents a summary of the alcohol priority indicators for LSAAs who will address alcohol related motor vehicle crashes, and presents non-illicit drug related indicators if the district will address the non-illicit drug priority. Data relevant to both priorities is provided for LSAAs who will address both priorities, with the caveat that all indicators are presented for Bear River and Tooele (even though they will only address one of the priorities) because they are the two LSAAs that need to determine which issue they will address.

Table 6. **Utah Local Substance Abuse Authority Allocations for SPF SIG including Priority Indicator Data Summary**

LSAA	# of Alcohol Related Crashes (2004)	Rate of Alcohol Related Crashes per 1 million VMT	# of Methadone ED Encounters (2003-05)	Rate of Methadone ED Encounters per 10,000	# of Other Narcotic[1] ED Encounters (2003-05)	Rate of Other Narcotic[1] ED Encounters per 10,000	# of Non-illicit Drug Deaths[2] (2005)	Rate of Non-illicit Drug Deaths[2] per 10,000	SPF SIG Funding Amount (Total)
Salt Lake County	883	10.85	236	0.82	718	2.5	120	1.28	**$2,214,526.12**
Utah County	242	6.67	68	0.52	339	2.58	48	1.19	**$1,101,630.34**
Weber District	168	10.04	41	0.63	159	2.44	27	1.25	**$1,042,097.89**
Southwest Utah	102	4.48	52	1.00	113	2.17	21	1.29	**$819,456.95**
Central Utah	n/a	n/a	25	1.18	41	1.94	10	1.46	$438,959.21
Davis County	136	5.79	n/a	n/a	n/a	n/a	n/a	n/a	$403,579.49
Northeastern	58	10.14	n/a	n/a	n/a	n/a	n/a	n/a	$325,000.00
Summit County	47	6.69	n/a	n/a	n/a	n/a	n/a	n/a	$325,000.00
Wasatch County	24	8.64	n/a	n/a	n/a	n/a	n/a	n/a	$325,000.00
Four Corners*	n/a	n/a	13*	.82*	46*	2.9*	5*	.94*	$325,000.00
San Juan*	n/a	n/a	13*	.82*	46*	2.9*	5*	.94*	$325,000.00
Tooele County	66	7.49	14	.93	29	1.92	5	1.00	$325,000.00
Bear River District	99	5.35	10	.23	59	1.34	13	.90	$325,000.00
Total Funding for Community Level Prevention Activities									**$8,295,250.00**

*The Four Corners and San Juan Districts comprise a single district within the Utah Department of Health System. As such, indicators collected through the Utah Department of Health represent the combined data for these two districts.

[1]The "Other Narcotics" classification code contains all narcotic drugs other than methadone and heroin, both of which have unique codes, and is primarily composed of painkillers.

[2]Data source: Utah Medical Examiner Data

3. IMPLICATIONS OF THE PLANNING MODEL/ALLOCATION APPROACH

Implications of the Planning Model/Allocation approach include considering whether: (1) the smaller LSAAs will be able to use as much money as they are allotted, (2) the larger metropolitan areas will receive adequate funds to complete the grant requirements, and (3) consumption and/or consequences can be reduced on a State and local level. At the State level we feel that it is important that each area receive enough money to build capacity in order to have the LSAAs meet the requirements of the grant but not so much so that there are funds left unspent. This consideration led to the selection of the allocation formula described above, which takes into account both population and need. Due to Utah's planned comprehensive approach, we expect to see change on both the State and local levels.

Each of the areas identified receives a set amount for Prevention Services from the State budget or the SAPT Block Grant. Some areas are already focusing on alcohol related issues, including motor vehicle crashes, or the impact of prescription drug abuse. They may use State allocated funds to supplement any programs, policies or practices that come about from the SPF SIG. However, the areas may not use SPF SIG funds to replace any state funding for programming or practices previously funded by the Block Grant or State budget.

After the LSAAs complete a Community Readiness Report for their identified priority(s), technical assistance will be provided to walk each LSAA through the next step of the 5 Step SPF process. Every LSAA is to complete all five steps of the SPF process. They are expected to build capacity and, when this has been demonstrated, move into implementation. All districts are expected to have done some implementation by the end of grant. However, they must demonstrate effective capacity building first. Districts must also submit a long-term budget that reflects changing costs over the years of the grant. At the State Level we will provide the necessary training that each area needs in the 5 Steps. We anticipate on having quarterly trainings on at least one of the 5 steps, analyzing data, evaluation or evidence based strategies.

Each LSAA will complete a community plan that outlines the following:

a. identifies their targeted communities within their areas,
b. intervening variables that impact the statewide issue,
c. identify what data they are utilizing
d. why they choose the data they did
e. assess their capacity to deal with prevention in their community
f. personnel, resources, and systems they have (including coalitions)
g. identify gaps
h. identify ability to collect, analyze and report data driven decision making in each step
i. discuss proposed evaluation plan and sustainability within each step
j. address cultural competency within your communities, or how you will address cultural competency

All 13 areas will complete community Readiness surveys. After the communities review their readiness surveys, they will decide if hiring or training staff and advisory boards is applicable. Then the LSAAs will each draft a plan of how they will implement the 5 step process, and eventually will define what activities best suit them to address their identified priority(s). At the State level, we will need to review how we can monitor the local areas. Areas

to address include whether the LSAAs need more TA, whether they are addressing the priorities. if they have a clear plan for implementation, and if their plans are culturally competent and sustainable. At the State level, we will strive to ensure that each area is culturally competent by reviewing the populations served and demographics of that specific area. We will encourage each area to review policies and programs provided to see that they are culturally sensitive and appropriate. As for sustainability, each area will be charged with identifying specific ways that they will sustain programming or funding in their area.

4. COMMUNITY-BASED ACTIVITIES

At this point, the LSAAs have not selected any programming or policies. However, each area will be embarking on the 5-Step Process. Each area will complete a readiness report and then assess what step their community needs to start with. A goal of the SPF-SIG is to support data-driven program planning and decision making at the state level so that each community can then engage with its local groups and agencies to facilitate such data-driven processes at the community level. Following SPF-SIG, program planning and interventions should focus on measurable substance use and abuse related outcomes. This emphasis on measurable outcomes represents a new focus for much of the substance abuse prevention community, both at the state and local level.

The State will maintain close contact with each of the LSAAs. Newsletters will be sent out bi-weekly to keep the LSAAs up to date with any changes or requirements from the State. Since there is a full time staff member at the State level, it will be her job to monitor and assess the technical assistance needs of the different areas. As stated before, most of the LSAAs are now trained in the Communities That Care planning model. The State will continue to provide assistance with this model and encourage the areas to follow the Strategic Prevention Framework Process.

As communities look at activities that will be funded by the SPF SIG, they will keep in mind that this funding is only temporary. From the beginning of the sub-recipient funding, sustainability of activities, programming or policies will be stressed. The State will aid in finding additional or alternative funding that will be congruent with each area's priorities and needs.

IMPLEMENTATION

The State of Utah has not reached the implementation phase of the 5 Step Process. It is our goal the once the State Strategic Plan is approved that we will visit with each of the LSAAs as needed and review what Technical Assistance they need prior to implementation of a strategy. It will be stressed that each area will follow the 5-step SPF process and that each area may have different strategies that best fit their communities. We plan on providing training and/or technical assistance not only on an as needed basis, but quarterly in collaboration with the Prevention Coordinator Network meetings. We will provide timely training on aspects of the 5-step SPF process with the assistance of WEST CAPT. The vision is that we will walk each area through the 5-Step SPF process. In addition, we will be accessible to the sub-recipients in the instance that they have questions or challenges arise.

We already have submitted a work plan with WEST CAPT for the LSAAs to receive technical assistance and training in the SPF process. The two areas of focus of TA will be

capacity building and evaluation at the community and program level. National Outcome Measures will also be an area needing TA from WEST CAPT.

From available data and reporting, we are aware of what programming and strategies are already in place in the LSAAs. Utah strives to be an advocate of prevention and new strategies. It is our goal that each of the sub-recipients utilizes the 5-Step process to identify new and appropriate strategies. The State will monitor to ensure that the areas are not supplanting programs by reviewing current area plans and data entered into the Prevention Administration Tracking System (PATS). We will also encourage and assist each area to work with their coalitions and any Drug Free community programs that are already in place.

EVALUATION

At the State level we have identified a Project Evaluator, Bach Harrison, L.L.C. Each of the local areas will be responsible for the costs associated with evaluation in their area. The cost will most likely vary from area to area due to need. The identified Project Evaluator has a program, Database Builder, which enhances data collection and analysis. In addition, the LSAAs will be entering the data on PATS, as described earlier. At the State, we will then compile the data into the appropriate reports.

At a minimum, we anticipate tracking demographic information, the number of people reached with the strategy or program, the immediate impact on the population, and process information (difficulties encountered, how was it delivered, etc). Most of this can be collected via PATS, but the process information will most likely collected in a report form from each of the LSAAs. We anticipate the impact will be collected by the evaluation component of the program or strategy.

We expect the numbers of alcohol related motor vehicle crashes, emergency department encounters of narcotics overdose, and non-illicit related deaths to decrease or maintain due to the efforts of the state and local agencies. At the LSAA level, we predict not only a decrease in the priority indicators, but an increase in awareness surrounding the issue and community participation. At the State level, we anticipate a stagnant rate due to a rapid increase in Utah's population. As this population increase is due to migration into the state (not simply birth rate), there will likely be a related increase in the number of violations. However, we are aiming for an overall decrease in numbers or rates.

Utah will also collect the National Outcome Measures as required by the grant. Bach Harrison, L.L.C., will be assisting the state and LSAAs in collecting the NOMs.

CROSS CUTTING COMPONENTS AND CHALLENGES

CULTURAL COMPETENCE

Our State SPF SIG plan will ensure the inclusion of cultural competence at all the steps at both State and Local levels by keeping in mind what cultural issues exist in each area. If an area requires additional culturally sensitive training, we will assist in providing that training. We acknowledge that each of the LSAAs have different cultural issues as well as challenges. We will keep in mind that what works in one area may not succeed in another. For example, what works in Weber County may not succeed within the Navajo reservations.

UNDERAGE DRINKING

Underage drinking has not been identified as a priority in and of itself for Utah's SPF SIG. However, the State of Utah has placed an emphasis on underage drinking evidenced by the recent allocation of funding from the State legislature. There is an Underage Drinking Workgroup that is a subcommittee from our advisory council, Utah Prevention Advisory Council. This UAD workgroup has coordinated a media campaign throughout the entire State. In addition, there is a program, Prevention Dimensions, that is implemented in schools, k-12, statewide. Prevention Dimensions is a curriculum that allows the lessons to be integrated into the regular academic curriculum. A challenge for our State is that while underage drinking is definitely an issue and a priority, the numbers at both the State level and community level are relatively low and therefore making it a separate priority did not make sense for Utah. However, underage drinking is included inasmuch as it contributes to the selected consumption pattern indicators for the identified priority of alcohol related motor vehicle crashes.

SUSTAINABILITY

The SPF Coordinator position is contracted through the end of the grant period. Over the next four years of the grant, the State will integrate the Strategic Prevention Framework 5-Step Process into the requirements of the SAPT Block Grant. Also, the data collection tool, PATS, will be sustained by the SAPT Block Grant as well as State funds. The hope is that the LSAAs will be able to build enough capacity in the early years of the grant with their SPF SIG funds that when the SPF SIG finally ends the local areas will have community support and the start up costs will no longer exist. They will then have to adjust their budgets to meet the continuing needs of their community. This will include the maintenance of their advisory boards. With previous grants, the infrastructure that was initially generated did not withstand the loss of funds. It is the State's hope that each area will maintain their advisory boards. During the course of the SPF SIG, the State will work with each area in searching for community buy in and finding alternative funding if necessary. This does not necessarily translate into the State providing the alternative funding. Ultimately having the community see the positive of having a prevention focused advisory board is a goal of the SPF SIG.

Also, we want to see the communities continue to collect data that will assist in their evaluation of programming or needs in the community. In addition we want each community to continue to do a community readiness survey biannually. This goal is aided by each community receiving technical assistance in Communities that Care – a planning model that guides communities in building effective coalitions and increasing community awareness. The State has already stressed the importance of surveying and involving community members to obtain the resources to sustain the surveying. We will provide accessibility to the tools necessary to find resources to maintain surveying. Community buy in is a must in order to acquire community resources or funding.

At the State level, we will maintain the advisory board, Utah Prevention Advisory Council. We will also maintain the State Epidemiological Outcomes Workgroup to continue collection and analysis of data throughout the state. In addition, we would like to publish an Epidemiological Profile every two years to reassess where the State of Utah is headed. We will continue to integrate the SPF 5-Step process into all areas of prevention as well.

CHALLENGES

As a Project Management Team, we faced some challenges identifying the State priorities. While we used a data-guided, "need based" allocation process, it was difficult to remove all subjectivity. For example, the relative importance you place on number versus rate gives a very different picture of the State and communities. We recognized the necessity of a certain degree of subjectivity and worked to be as data driven within those constraints as possible. As noted in this plan, the lack of data has posed a challenge. However, we are optimistic that during the course of the SPF SIG, Utah will improve the collection and availability of substance abuse related data.

Initially during implementation, we expect the LSAAs to feel overwhelmed at the beginning of the process. We also expect both community and programming levels to struggle with adequate data collection and analysis. For these reasons we have committed to frequent Technical Assistance and are working with a Project Evaluator that will help with the data issues. We also acknowledge that there are political issues that will impact certain areas and the implementation of the grant. These may include little or no community support, jumping ahead of the process (selecting a program prior to completing the process), the ability of the prevention services to reach the targeted populations, such as a weak community advisory board. We are prepared to provide support and assistance to the areas that encounter these problems by visiting with key leaders (as requested) and looking at alternative venues to getting community buy in.

TIMELINE

Timeline for Project Management

Key Activities	YEAR 1 Quarter				YEAR 2 Quarter				YEAR 3 Quarter				YEAR 4 Quarter				YEAR 5 Quarter				Responsible Parties
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
Hire Project Staff	S																				PI, PD
Step 1: Profile Population Needs, Resources, and Readiness to Address the Problems and Gaps in Service Delivery																					
Conduct Needs Assessment		S	S		C		S				S				S				S		SEOW, BH
Convene SEOW	S																				PI, PD
Promote the SPF at the Community Level	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	PI, PD, PC, UPAC
Use Epidemiological Data to Assess SA Problems and Risk/Protective Factors						C		C				C				C				C	LSAAs
Identify Target Populations							C		C				C				C				LSAAs
Determine Assets, Resources, Gaps, and Readiness						C		C				C				C				C	LSAAs
Step 2: Mobilize and/or Build Capacity to Address Needs																					
Add Key Stakeholders to Advisory Councils	B																				UPAC, LSAAs
Enhance Cultural Competence	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	ALL
Address Sustainability																					ALL
Step 3: Develop a Comprehensive Strategic Plan																					
Develop Culturally Competent ,Sustainable Plans				S	C																UPAC, SEOW, LSAAs
Plans Approved					S	C															CSAP/DSAMH
Revise Strategic Plans								S	C			S	C			S	C			S	UPAC, SEOW, LSAAs
Step 4: Implement Evidence-Based Prevention Programs and Infrastructure Development Activities																					
Disburse Funds to Target Communities						S		S				S				S				S	DSAMH
Support Communities w/ Infrastructure Development and Selection of Effective Programs						S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	PI, PD, PC, BH
Select and Implement Effective Policies, Programs, and Practices						C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	LSAAs
Ensure Culturally Competent Adaptations of Programs						B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	DSAMH, LSAAs, BH
Step 5: Monitor Process, Evaluate Effectiveness, Sustain Effective Prevention Programs/Activities, and Improve or Replace Those That Fail																					
Conduct Evaluation/Make Appropriate Adjustments	S	S	S	S	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	BH
Sustain Effective Programs and Outcomes			B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	ALL

S – State Role C – Community Role (spearheaded by LSAAs) B – Both State and Community Role
LSAAs – Local SA Authorities PI – Principle Investigator UPAC – Utah Prevention Advisory Council
PC – Project Coordinator DSAMH – State Division of SA/MH PD – Project Director
SEOW-State Epidemiological Outcomes Workgroup BH – Bach Harrison/Evaluators

APPENDIX A: EPIDEMIOLOGICAL PROFILE TABLES

Alcohol Use Consequences

	Indicator	Years	Average Annual Number of Cases	Average Rate per 100,000 Population	UT:USA Rate Ratio	Trend	Time from Use to Outcome	Strength of Relationship	Data Source	
Mortality	Alcohol Related Motor Vehicle Crash Fatalities	2000-2004	73.5	32	0.53	Stable	Immediate	Strong	13	
	# of Fatal Alcohol Related Vehicle Crashes	2000-2004	64.8	28	0.53	Stable	Immediate	Strong	13	
	Proportion of Fatal Motor Vehicle Crashes Related to Alcohol	1990-2003	26%	41%	0.63	Slightly Decreasing	Immediate	Medium	13	
	Alcoholic Cirrhosis	1990-2001	52	2.6	0.57	Stable	Distant	Strong	19-23	
	Other Cirrhosis	1990-2001	56	2.8	0.54	Stable			19-23	
	Alcoholism Fatalities	1999-2005	37	1.6	Not Available	Slightly Decreasing		Strong	3	
Morbidity	Emergency Department Encounters with ICD-9 980.0, Toxic Effect of Alcohol	1999-2004	385	16.5	Not Available	Slightly Decreasing	Immediate	Strong	4	
Other Consequences	Alcohol Dependence or Abuse	2002-2004	*Estimated* 125,802*	*Estimated* 6816*	*Estimated* 0.89*	Stable	Variable	Strong	16	

Tobacco Use Consequences

	Indicator	Years	Average Annual Number of Cases	Average Rate per 100,000 Population	UT:USA Rate Ratio	Utah Trend	Time from Use to Outcome	Strength of Relationship	Data Source	
Mortality	Lung Cancer	1990-2001	358	17.7	0.32	Stable	Distant	Strong	19-23	
	Ischemic Cerebrovascular Disease	1990-2001	3,182	159.0	0.53	Decreasing	Distant	Strong	19-23	
	Cardiovascular Disease	1990-2001	414	19.3	0.73	Increasing*	Distant	Strong	19-23	
	Other Lung Diseases	1990-2001	424	20.9	0.56	Stable	Distant	Strong	19-23	
	Extent to which Tobacco Contributed to Death (probably contributed or was underlying cause of death)	1999-2004	1,422	61.1	Not Available	Decreasing	Distant	Strong	7	

Other Drug Use Consequences										
	Indicator	**Years**	**Average Annual Number of Cases**	**Average Rate per 100,000 Population**	**UT:USA Rate Ratio**	**Trend**	**Time from Use to Outcome**	**Strength of Relationship**	**Data Source**	
Mortality	Accidental and Undetermined Intent Drug Poisoning Deaths	1999-2004	222	9.4	Not Available	Increasing	Immediate	Strong	7	
	Drug Use	1990-1998	4	0.22	0.44	Increasing	Immediate	Strong	19-23	
	Intentional (Suicide) Drug Poisoning Deaths	1999-2004	44	1.9	Not Available	Increasing	Immediate	Strong	7	
	Number of Non-Illicit Drug Poisoning Suicides Deaths	1991-2005	37	1.7	Not Available	Stable	Immediate	Strong	9	
	Number of Drug Poisoning Deaths Investigated by the Medical Examiner	1991-2005	215	Not Applicable	Not Available	Increasing	Immediate	Strong	9	
	Number of Accidental and Undetermined Intent Illicit Drug Poisoning Deaths	1991-2005	75	3.4	Not Available	Increasing, then Stable	Immediate	Strong	9	
	Number of Accidental and Undetermined Intent Non-Illicit Drug Poisoning Deaths	1991-2005	76	3.3	Not Available	Increasing	Immediate	Strong	9	
Morbidity	Emergency Department Encounters for Narcotics Overdose (ICD-9 CM 965.x)	1999-2004	2,368	101.3	Not Available	Increasing	Immediate	Strong	4	
Other Consequences	**Reported Property Crimes**	**2000-2003**	**94708.5**	**41.21**	**1.2**	**Stable**		**Medium**	**12**	

Indirect Outcomes of Substance Use

	Indicator	Associated Substance	Years	Average Annual Number of Cases	Average Rate per 100,000 Population	UT:USA Rate Ratio	Trend	Time from Use to Outcome	Strength of Relationship	Data Source	
Mortality	Homicides	Alcohol	1990-1998	61	3.1	0.36	Slightly Decreasing	Variable	Low-Medium	19-23	
	Suicides*	**Alcohol**	**1990-2001**	**289**	**14.3**	**1.2**	**Stable**	**Variable**	Low-Medium	**19-23**	
	Falls	Alcohol	1999-2005	97	4.1	Not Available	Increasing	Short	Low-Medium	3	
	Accidental Drowning and Submersion	Alcohol	1999-2005	24	1	Not Available	Stable	Short	Low-Medium	3	
	Accidental Deaths due to Fires	Tobacco	1999-2005	10	0.4	Not Available	Stable	Short	Low-Medium	3	
Other Outcomes	Reported Violent Crimes	Illicit Drugs	2000-2003	5,496	2,390	0.51	Slightly Rising Since 2001	Variable	Medium	12	

Estimates of Alcohol Use

	Indicator	Age Category	Year	Utah	USA	Utah:USA Ratio	Utah Trend	Data Source	
Youth	30 Day Alcohol (%)	Grade 6	2005	2.1	N/A	N/A	Stable	10,27	
		Grade 8	2005	9.3	17.1	0.54	Slightly Increasing	10,27	
		Grade 10	2005	15.7	33.2	0.47	Stable	10,27	
		Grade 12	2005	20.5	47.0	0.44	Decreasing	10,27	
		College Enrolled	2005	22.1	67.9	0.33	Increasing	8,27	
	Binge Drinking (%) (5 or more drinks in the past 2 weeks)	Grade 6	2005	1.7	N/A	N/A	Stable	10,27	
		Grade 8	2005	5.7	11.4	0.50	Slightly Increasing	10,27	
		Grade 10	2005	9.7	22.0	0.44	Slightly Increasing	10,27	
		Grade 12	2005	13.3	29.2	0.46	Decreasing	10,27	
		College Enrolled	2005	11.7	40.1	.29	Slightly Increasing	8,27	
Adult	At risk for binge drinking (%)		1995, 1997, 1999, 2001–2005	9.4	15.5 (2002–05)	0.61 (2002–05)	Stable	1,25	
	At risk for chronic drinking (%)		1989–1993, 1995, 1997, 1999, 2001–2005	2.8	5.4 (2002–05)	0.55 (2002–05)	Stable	1,25	
	Drank alcohol during last 3 months of pregnancy (%)		1999–2003	2.9	5.6 (2002)	0.54 (2002)	Decreasing	5,26	
	Alcohol use during pregnancy (%)		1989-2005	1.1	N/A	N/A	Stable	2	
	Population adjusted alcohol sales (gallons/person)		1990-2002	1.28	2.21	0.58	Stable	17	
	Current alcohol use (%)		2002-2003	29.6	50.5	0.59		16	
	Binge Alcohol Use (%)		2002-2003	15.9	22.8	0.70		16	
	Alcohol Dependence or Abuse (%)		2002-2003	6.9	7.6	0.91		16	

Estimates of Tobacco Use

	Indicator	Age Category	Year	Utah	USA	Utah:USA Ratio	Utah Trend	Data Source	
Youth	30 Day Smoking (%)	Grade 6	2005	0.8	N/A	N/A	Stable	10,27	
		Grade 8	2005	2.8	9.3	0.30	Stable	10,27	
		Grade 10	2005	6.0	14.9	0.40	Slightly Increasing	10,27	
		Grade 12	2005	8.0	23.2	0.34	Slightly Decreasing	10,27	
		College Enrolled	2005	7.9	23.8	.33	Decreasing	8,27	
	Chronic Heavy Smoking (%) (1/2 pack or more/day)	Grade 6	2005	0.0	N/A	N/A	Stable	10,27	
		Grade 8	2005	0.3	1.7	0.18	Stable	10,27	
		Grade 10	2005	0.8	3.1	0.26	Stable	10,27	
		Grade 12	2005	1.3	6.7	0.19	Slightly Decreasing	10,27	
Adult	Current smoking (%)		1989-2005	13.9	22.4 (1995-2005)	0.58 (1995–2005)	Decreasing	1,25	
	Current Cigarette Use (%)		2002-2003	16.74	25.71	0.65		16	
	Attempted to quit smoking this year (%)		1994-2005	52.3	N/A	N/A	Slightly Increasing	1,25	
	Population adjusted tobacco purchasing (annual packs/person)		1990-2002	47.7	87.9	0.56 (2000-2002)	Decreasing	18	
	Smoked during last 3 months of pregnancy (%)		1999-2003	6.4	13.1 (2002)	0.49	Decreasing	5,26	
	Smoked during pregnancy (%)		1989-2005	6.9 (2000-2005)	N/A	N/A	Decreasing	2	

Estimates of Other Drug Use

		Age Category	Year	Utah	USA	UT:USA Ratio	Utah Trend	Data Source	
Youth	30 Day Inhalant Use (%)	Grade 6	2005	3.8	N/A	N/A	Slightly Increasing	10,27	
		Grade 8	**2005**	**5.3**	**4.2**	**1.26**	**Stable**	**10,27**	
		Grade 10	**2005**	**3.1**	**2.2**	**1.41**	**Stable**	**10,27**	
		Grade 12	2005	1.6	2.0	0.80	Decreasing	10,27	
		College Enrolled	2005	0.2	0.3	0.67	Stable	8,27	
	30 Day Marijuana Use (%)	Grade 6	2005	0.4	N/A	N/A	Stable	10,27	
		Grade 8	2005	3.0	6.6	0.45	Stable	10,27	
		Grade 10	2005	7.4	15.2	0.49	Slightly Increasing	10,27	
		Grade 12	2005	9.5	19.8	0.48	Slightly Decreasing	10,27	
		College Enrolled	2005	4.6	17.1	0.27	Decreasing	8,27	
	30 Day "Any Drug Use" (%)	Grade 6	2005	5.6	N/A	N/A	Stable	10,27	
		Grade 8	2005	9.8	11.8	0.83	Stable	10,27	
		Grade 10	2005	13.3	19.4	0.68	Slightly Increasing	10,27	
		Grade 12	2005	14.0	23.2	0.60	Decreasing	10,27	
		College Enrolled	2005	7.4	19.5	0.38	Slightly Decreasing	8,27	
Adult	Current Marijuana Use		2002-2003	4.0	6.2	0.65		18	
	Current Other Illicit Drug Use		2002-2003	3.7	3.7	1.00		18	
	Drug Dependence or Abuse		2002-2003	2.9	3.0	0.97		18	

Appendix B: References

References:

Data for the Epidemiological Profile were accessed through several different sources.

Utah has developed an internet portal through which data are available to the public and to researchers. The Indicator Based Information System (IBIS) http://ibis.health.utah.gov/home/welcome.html includes vital statistics, health survey, hospital inpatient and emergency department data. Utah-specific data accessed using this system include:

1. Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health

2. Utah Birth Certificate Database, Office of Vital Records and Statistics, Utah Department of Health

3. Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health

4. Utah Emergency Department Encounter Database, Bureau of Emergency Medical Services, Utah Department of Health

5. Utah Pregnancy Risk Assessment Monitoring System (PRAMS), Utah Department of Health

Additional Utah-specific data were acquired using original data sources rather than the IBIS internet portal.

6. Safe and Drug-Free Schools and Communities Monitoring Data. Utah State Office of Education.

7. Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health

8. Utah Higher Education Health Behavior Survey. Utah Department of Human Services, Division of Substance Abuse and Mental Health and the Utah Department of Health, 2003-2005. Accessed via http://www.dsamh.utah.gov/higher_ed.htm

9. Utah Medical Examiner Database, Office of the State Medical Examiner, Utah Department of Health

10. Utah Prevention Needs Assessment Survey. Utah Department of Human Services, Division of Substance Abuse and Mental Health, 2003-2005. Accessed via http://www.hsdsa.state.ut.us/sharp.htm

The Center for Substance Abuse Prevention Data Coordinating Center (CSAP DCC) created an online data warehouse to assist State Epidemiological Workgroups. The State Epidemiological

Data System (SEDS) is an internet portal http://www.epidcc.samhsa.gov/default.asp that includes data from health surveys, government databases, vital statistics, and tax collection. Data acquired through this system include:

Census

11. National Center for Health Statistics. Bridged-race intercensal estimates of the July 1, 1990-July 1,1999, United States resident population by county, single-year of age, sex, race, and Hispanic origin, prepared by the U.S. Census Bureau with support from the National Cancer Institute (April 24, 2004). Estimates of the July 1, 2000-July 1, 2003 , United States resident population from the Vintage 2003 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau (September 14, 2004).

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12. United States Department of Justice, Federal Bureau of Investigation. Uniform Crime Reporting Program Data [United States]: County-Level Detailed Arrest and Offense Data, 1994-2002 [Computer files]. ICPSR ed. Ann Arbor, MI: Inter-University Consortium for Political and Social Research [producer and distributor], 2004.

Fatal Accidents

13. National Highway Traffic Safety Administration, 2004. Fatality Analysis Reporting System (FARS), 2003. Department of Transportation, National Highway Traffic Safety Administration.

Health Behaviors

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Appendix C: Description of Utah-Specific Data Sources

Description of Utah Data Sources

Utah Death Certificate Database (References 3,7)

Death certificates in Utah are required to be filed by funeral directors. Funeral directors obtain demographic information from an informant, a close family member of the decedent. The cause of death is certified by the decedent's physician or the physician that attended the death. Accidental and suspicious deaths are certified by the Medical Examiner. Death certificate data go through extensive edits for completeness and consistency. The Office of Vital Records and Statistics does annual trainings for funeral directors and local registrars.

When death certificates are received the cause of death literals are keyed into software locally by Office of Vital Records and Statistics (OVRS), then shipped to the National Center for Health Statistics where they are machine coded into ICD-10 codes. NCHS returns the ICD-10 codes to OVRS where the death records are updated.

Utah Birth Certificate Database (Reference 2)

Birth certificates are filed electronically by hospital birth certificate clerks. The information comes from a variety of sources including a worksheet the mother fills out, the mother's prenatal record, and the delivery record. The Office of Vital Records and Statistics has a Quality Control program where every hospital is audited annually. Births are randomly selected and hospital records are checked to verify the accuracy of the reported information.

Utah Emergency Department Encounter Database (Reference 4)

The Emergency Department Encounter Database (ED) contains the consolidated information on complete billing, medical codes, personal characteristics describing a patient, services received, and charges billed for each patient emergency department (ED) encounter. The Bureau of Emergency Medical Services/Office of Health Care Statistics receives quarterly Emergency Department Encounter Data form hospitals in various formats and media. The data are converted into a standardized format. The data are validated through a process of automated editing and report verification. Each record is subjected to a series of edits that check for accuracy, consistency, completeness, and conformity with the definitions specified in the Utah Hospital Emergency Patient Encounter Data Submittal Manual. Records failing the edit check are returned to the data supplier for corrections of comment.

Coverage and Validity of Diagnosis Codes: Since the data come from the billing forms, all visits or encounters have a diagnosis code making coverage great. There is some difference of opinion regarding whether some providers may emphasize diagnosis codes that yield higher reimbursements. The hospital and ED data are considered /"Administrative Data/" because they were created for use in billing and remittance of payment. As such, they were not constructed for public health surveillance purposes primarily, and are weak in some areas, such as external cause of injury and race or ethnicity. But, in general, they are extremely valuable and reasonably complete and valid.

Utah Pregnancy Risk Assessment Monitoring System (PRAMS) (Reference 5)

PRAMS, the Pregnancy Risk Assessment Monitoring System, is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy
PRAMS was initiated in 1987 because infant mortality rates were no longer declining as rapidly as they had in prior years. In addition, the incidence of low birth weight infants had changed little in the previous 20 years. Research has indicated that maternal behaviors during pregnancy may influence infant birth weight and mortality rates. The goal of the PRAMS project is to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS provides state-specific data for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health.

Utah Medical Examiner Database (Reference 9)

Utah has a state-wide, centralized medical examiner system that has statute mandated jurisdiction over sudden and unexpected deaths. The database contains 113 variables including demographic information about the decedent, toxicological, laboratory, and autopsy examination results.

Utah Prevention Needs Assessment Survey (Reference 10)

The Utah Department of Human Services, Division of Substance Abuse and Mental Health has conducted a prevention needs assessment survey for youth across the state on a bi-annual basis starting in 2003. The PNA survey measures youth substance use rates in a variety of substance categories as well as antisocial behaviors such as theft, violence, and school suspension. The survey is based on the Risk and Protective Factor Model of Youth Problem Behavior (Hawkins, Catalano, & Miller, 1989), and also contains several scales measuring various risk and protective factors associated with substance use and other problem behaviors (e.g., school drop out, deliquency, etc.).

Utah Higher Education Health Behavior Survey (Reference 8)

The Utah Department of Human Services, Division of Substance Abuse and Mental Health and the Utah Department of Health have collaborated to conduct a prevention needs assessment survey for the higher education population across the state on a bi-annual basis starting in 2003. Like the youth-oriented PNA Survey, the higher education survey is based on the Risk and Protective Factor Model of Youth Problem Behavior (Hawkins, Catalano, & Miller, 1989). The survey measures substance use rates in a variety of substance categories, antisocial behaviors, and risk and protective factors relevant to the higher education population that are associated with substance use.

Utah Safe and Drug Free Schools and Communities Program Monitoring Data (Reference 6)

The Utah State Office of Education collects annual data from each school about incidents of prohibited behavior, including possession and use of substances, that occur on school grounds/property or during school activities. Data include the type of violation (weapons, substances, assault etc.), number of incidents, number of offenders, results of the incident (e.g.

expulsion or referral to law enforcement). Data are collected at the school level and reported publicly only at the district level or higher. State-level data are included for this report.